

Personal Details of Participant

First Name: _____ Surname: _____ Tutor Group: _____

Date of Birth: ___ / ___ / ___ Age: _____ Male / Female (delete as appropriate)

Address: _____

Post Code: _____

Next of Kin – name and address during the activity (if different from above) _____

Contact Numbers – Home: _____ Work: _____ Mobile: _____

Any special dietary requirements: _____

Medical Information

Name and address of participant’s Doctor: _____

Telephone Number: _____ NHS Number (if known): _____

Has the participant HAD or HAVE any of the following? *Where ‘YES’, please give specific details overleaf.*

Asthma or bronchitis	Yes	No	Allergies to any know medication	Yes	No
Heart condition	Yes	No	Other allergies (material, food, animal, plasters)	Yes	No
Fits, fainting or blackouts	Yes	No	Other illness, disability or special needs	Yes	No
Severe headaches	Yes	No	Travel sickness or sleepwalking	Yes	No
Diabetes	Yes	No	Regular medication	Yes	No

Has the participant received vaccination against Tetanus in the last 10 years? Yes No

Is the participant receiving -

Support and/or treatment for mental health from their counsellor or Doctor? Yes No

Medical or surgical treatment of any kind from their Doctor or hospital? Yes No

Has the participant been given specific medical advice to follow in emergencies? Yes No

If the answer to any of these questions is Yes, please give details below (including name and dosage of any medicines/tablets)

If considered necessary, do you consent to the following?

Mild painkillers (Paracetamol) being administered? Yes No

Sun screen being provided? Yes No

Additional Consent, Medical or Special Needs Information

(Add additional sheets if required)

Image Consent

Do you consent to your child's image taken during this visit being used by the school?
YES / NO

Consent for the Visit

I confirm that I have parental responsibility for _____

He/she is in good health and I consent to him/her taking part in **ALL** activities set out in the visit information.

I am aware that the travel insurance synopsis is available for viewing in school / the Establishment.
In the event of illness or accident, I consent to any necessary medical treatment, which might include the use of anaesthetics. In the event of any change to these details, illness or medical treatment occurring after the return of this form and prior to the activity, I will undertake to inform the group leader.

_____ Print name here: _____
Signed by person with parental responsibility

GDPR Statement

By signing this form, I confirm my agreement to School / Establishment processing my / my child's personal data for the purpose of supervising and supporting my child on an educational visit. We do this to meet our professional responsibilities to look after you / your child.

This data may be shared with outdoor providers, doctors and other professionals to help us keep you / your child safe.

This data will be retained for one year, other than in the event of an accident/ incident, in line with HCC / School Retention Policy.

You have some legal rights in respect of the personal information we collect from you.

Please see our website Data Protection page for further details: www.hants.gov.uk/dataprotection